



Kelley Counseling PLLC

1145-D Executive Circle
Cary, NC 27511
919-249-5423

Client Information Form

Date _____

DOB: _____

Client Name: _____
Last _____ First _____ Middle _____

Mailing Address

Email address: _____

Phone : (Home) _____ (Work) _____ (Cell) _____

Marital Status: _____

Spouse Name: _____ Phone: _____
Spouse Employer: _____ Phone: _____

If under 18 years of age:
Guardian Names/ Contact # / Relationship

Insurance Information (if self-pay client please omit)

Provider: _____

Billing Address: _____

Group # _____ ID# _____

Phone for Provider _____

Employer or School: _____

Name _____

Phone Number _____

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Medications or Supplements: _____

Emergency Contact (Name/#): _____

What do I want out of therapy and or what are my goals?

Any requests and or preferences (i.e. time of appointment, certain treatments to try or avoid, people you wish to include in your treatment):

I look forward to working with you to improve on these goals!